Tots to Teens Pediatrics
building healthy futures

Authorization to Release Medical Information

I AUTHORIZE: **Release To**

Tots To Teens Pediatrics _____

619 W FM 544 Suite 1B
Murphy, TX 75094
Ph No. 972-4247915
Fax No. 972-4243652

City:_____ State:_____Zip Code_____

Ph No:_____

Fax No:_____

PATIENT NAMES & D.O.B

_____

_____

_____

INFORMATION TO BE RELEASED: (Circle All Applicable)

• All Information	• All Progess Notes	• Lab Report	• X-ray Report
• Hospital Record	• Growth Chart	• Immunization Record	• Others

3. Records From the Time Period : (/ /) through (/ /)

4. Purpose of Disclosure : (May Leave Blank) _____

5. I understand that this authorization shall be valid for (1) year. I understand that I may revoke this consent at any time except to the extent that this action has already been taken.

6. I understand that the requester may not lawfully further use or disclose this health information unless another authorization is obtained from me or unless disclosure is required or permitted by law.

7. I understand that I may be provided with a copy of this authorization. I understand that this information will be provided within 15 business days of the request.

Parent Guardian Signature:_____

Home #: _____Cell #:_____Work #:_____

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